Request for Private Duty Nursing Services

MOUNTAIN PACIFIC QUALITY HEALTH FOUNDATION

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P.O. Box 6488
Helena, Montana 59604

Phone# 406-443-4020 or 1-800-262-1545 ext 150
Fax #: 406-443-4585

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REQUEST FOR AUTHORIZATION OF PRIVATE DUTY NURSING SERVICES

Complete all areas, which apply to the recipient:

Medicaid #: _____SEX___DOB_____
Name: Last_____First_____MI___
Address: _____ City: _____ State: _____Zip: _____
Provider #: _____Provider Name: _____ Location: _____
Phone #: _____Fax: _____
Signature of person completing review: _____

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NUMBER OF HOURS REQUESTED PER DAY: _____

Physician Name: _____Diagnosis: _____
Reason services are being requested: _____

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SCHOOL SERVICES: (Complete all blanks in this section)

* Date school year starts: _____ Date school year ends: _____
* Attends how many days a week: _____ Daily schedule: _____
* Who actually administers medications to students: _____
* Can med administration times be shifted so they do not have to be given at school? _____
* Medications to be given / freq.: _____
* Other skilled needs type / freq. IE: (catheterization, wound care)_____

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HOME SERVICES: Tube feeding /amount /frequency (attach copy of history and physical _____ and DR orders)

_____

*Routine Meds / frequency: Suction / Respiratory treatments:_____

_____ _____
_____ _____
_____ _____

OTHER SKILLED NEEDS (IE: sterile dressings B.I.D.)

_____ _____
_____ _____
_____ _____

If medications or treatments are ordered PRN- keep accurate records of date, times and duration of treatments. Submit a request for additional units at the end of the date span.

Foundation Use Only: Review Type:_____ **Review Category:** _____
Approved: From_____ **Thru**_____ **hour units**_____
Denied: From _____ **Thru** _____ **hour units**_____ **codes:** _____